

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/04/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WILLIAM N WISHARD MEMORIAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>1001 W 10TH ST INDIANAPOLIS, IN 46202</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State hospital complaint investigation.</p> <p>Complaint: #IN00111579 Unsubstantiated; lack of sufficient evidence</p> <p>Survey Date: 01/04/13</p> <p>Facility: # 005023</p> <p>Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor</p> <p>William N Wishard Memorial Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 01/14/13</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1